EXECUTIVE SUMMARY

PURPOSE

To determine how and to what extent hospital ownership of home health agencies or nursing homes impacts hospital discharge planning for Medicare beneficiaries.

BACKGROUND

Hospital discharge planning is a process where a plan is developed for a patient to receive appropriate post-hospital placement and services.

A significant reduction in the average length of stay for acute care hospital patients created a greater need for post-hospital services such as home health and nursing home care. These reductions are widely believed to be associated with advances in medical technology as well as the implementation of the Medicare prospective payment system. As the average hospital stay decreases, the role of the hospital discharge planning process has become more critical.

This study focuses on discharge planning for patients who are referred to home health agencies or nursing homes owned by their discharging hospitals. We based our results on: utilization data for the hospital and post-hospital stays for a stratified random sample of Medicare beneficiaries who had been discharged from a hospital and went to either a home health agency or a nursing home; mail questionnaires sent these Medicare beneficiaries; mail questionnaires sent to discharge planners from the beneficiaries' discharging hospitals; and a review of materials related to the discharge planning process that were submitted to us by the discharge planners.

FINDINGS

Hospital ownership seems to have little influence on which nursing homes patients are referred to

We analyzed the discharge process experienced by beneficiaries in our sample who went to a nursing home. Regardless of whether the nursing home was owned by the discharging hospital, nursing home beneficiaries report having input in the referral process. Only 13 percent of them say, "the hospital just told me where to go." Only a quarter of beneficiaries report "no say" in the decision about which nursing home to choose. Many beneficiaries report that the decision to go to a particular nursing home was made by a relative. Of nursing home patients who were discharged from a hospital that owned a nursing home, only 40 percent went to the one owned by the discharging hospital.

However, it does influence the length of stay in both the hospital and the nursing home

There has been concern and some evidence that hospitals which own nursing homes discharge patients sooner to their own facilities and those patients stay in the facilities longer.

This raises the question of whether hospitals are lowering their costs for patients for whom they are receiving a lump sum prospective payment from Medicare and discharging those same patients to post-hospital services for which they are being paid on a cost basis. This cost shifting would result in increased Medicare reimbursement for the hospital.

When we analyzed relevant data for beneficiaries who got services from hospital-owned nursing homes, we found additional evidence supporting this concern. We found a statistically significant difference in the length of hospital stays; beneficiaries discharged to the hospital-owned nursing homes had average hospital stays of 6.8 days, as compared to 8.9 days for those beneficiaries who went to a nursing home independent of their hospital. In addition, we found a statistically significant difference in the length of nursing home stays; beneficiaries who went to the hospital owned nursing home averaged a 37 day nursing home stay while those who went to a nursing home independent of their hospital averaged a 29 day nursing home stay. This supports the concern that hospitals are shifting patients from acute care, reimbursed under a lump sum prospective payment, to post-acute care in nursing homes, which is reimbursed on a cost basis, thus maximizing Medicare reimbursement.

Hospital ownership does seem to have influence on which home health agencies patients are referred to

Many beneficiaries report not having full choice in selecting a home health agency. In contrast to nursing home beneficiaries, 38 percent of home health agency beneficiaries who went to hospital-owned agencies report that the hospital "just sent home care people to them." Again, in contrast to nursing home beneficiaries, focusing only on home health patients who were discharged from a hospital that owned a home health agency, we found that fully 62 percent of them went to the agency owned by the discharging hospital.

Discharge planners from hospitals which own home health agencies report that hospital ownership is a factor in their referral process to home health agencies: 19 percent report that, unless patients or families object, they refer all patients to their hospital-owned agency and almost 10 percent believe that someone from the hospital puts pressure on patients to choose a particular home health agency. Finally, hospitals owning home health agencies are more likely to have referral procedures than those which do not own agencies.

Hospital ownership also influences the duration of home health agency services

There was a statistically significant difference with regard to the length of home health agency services; those beneficiaries that received services from a home health agency owned by the hospital they were discharged from averaged 49 days of service while those receiving care from a home health agency independent of their hospital averaged 37 days of service. However, no statistically significant difference in the length of the hospital stay was found when comparing hospital stays for beneficiaries who received care from a home health agency owned by their discharging hospital to stays for those beneficiaries who received care from an agency independent of their discharging hospital.

Beneficiaries who go to hospital-owned nursing homes and home health agencies report better continuity of care

One goal of the discharge planning process is to promote a strong connection between the care provided in the hospital and the care given by the home health agency or nursing home. It is generally assumed that if discussions are held with patients regarding their post-hospital needs and how they can be addressed, the likelihood that these needs will be met is improved. It is also assumed that the earlier discussions are held and the more comfortable beneficiaries are with the timing of their hospital discharge, the better the continuity of their care will be.

Beneficiaries who went to hospital-owned home health agencies are more likely than those who got independent services to report: having been discharged at the right time (89 versus 77 percent); knowing what healthcare services they are supposed to get after leaving the hospital (92 versus 83 percent); and, that the connection between their care providers was very good (88 versus 43 percent). Those who went to hospital-owned nursing homes were more likely to report: having been talked to early; having been talked to about the post-hospital services they thought they would need (95 versus 61 percent); having been discharged at the right time; and, that their overall health improved (77 versus 43 percent).

Hospital ownership does not impact beneficiaries' level of satisfaction

Both home health agency and nursing home beneficiaries report high levels of satisfaction with the discharge planning process. Their satisfaction does not differ based on ownership.

RECOMMENDATIONS

Our findings suggest that hospital ownership of nursing homes plays a significant role with regard to the nursing home beneficiary utilization patterns. The hospital stay is shorter and the nursing home stay longer thus the hospital may be shifting cost from a prospective payment system to a cost-based system, maximizing Medicare reimbursement. Therefore, we recommend the following:

- The HCFA should develop statistical methods to target for special review providers who may be maximizing their Medicare reimbursement in this way. The records of these providers should be reviewed by the Peer Review Organizations, as in the past, or through some other suitable mechanism. Providers who are found to be inappropriately discharging beneficiaries to their own nursing homes should be subject to payment adjustments and appropriate fines or penalties.

Our findings also suggest that hospital ownership plays a significant role in home health agency referral discussions and some role, albeit a lesser one, in nursing home referral discussions. In addition, we found that many Medicare beneficiaries do not have full choice in selecting a home health agency or nursing home. Therefore, we recommend the following:

- The HCFA should assure that hospitals disclose ownership of home health agencies and nursing homes in a systematic way.

    - Hospitals which own home health agencies and nursing homes should be required to disclose the names of the home health agencies and nursing homes which they own to all beneficiaries who are possible candidates for these post-hospital services.

    - Hospitals which own home health agencies and nursing homes should be required to disclose this information to HCFA.

- The HCFA should take additional measures to assure that when beneficiaries are being discharged from the hospital they are given a choice in selecting a home health agency or nursing home from which to receive care.

    - Hospitals should be required to inform patients (or their families) that they are free to choose among home health agency providers and nursing homes. This information should be provided as early as possible.

    - Hospitals should maintain a file of Medicare participating home health agencies and nursing homes in the area and provide beneficiaries (or their families) with a list of alternatives which are appropriate for the level of care they need.

- Since our findings support the need for additional Medicare beneficiary information related to post-hospital services and choice, we recommend that HCFA prepare information for beneficiaries addressing this issue and circulate it widely.

1997 BALANCED BUDGET ACT

The 1997 Balanced Budget Act includes a provision which addresses the concern that some hospitals are shifting costs from a prospective payment system to a cost-based system, thus maximizing Medicare reimbursement. Section 4407 of this recently enacted law redefines beneficiaries with certain diagnoses who are discharged from hospitals to nursing homes and home health agencies (as well as other prospective payment exempt settings) as "transfers." This law limits payments to hospitals for these cases.

This recently enacted law addresses the concern disclosing hospital ownership information and Medicare that beneficiaries are informed of their freedom to choose the home health agency or nursing home to which they will be referred. Section 4321 of the 1997 Balance Budget Act requires hospitals referring patients to home health agencies (HHA) and other post-hospital providers to:

- not specify or otherwise limit beneficiaries in terms of which post-hospital service provider they receive services from;

- provide beneficiaries with information on HHAs and other post-hospital providers which serve the area;

- disclose to the beneficiary any financial interest which the hospital may have in an HHA or other post-hospital provider to which they are referred; and,

- disclose to HCFA the nature of any financial interest which the hospital has in a home health agency or other post-hospital service provider, as well as related referral rate information.

The HCFA is in the process of implementing both of these new provisions.

COMMENTS

We received comments on the draft report from the Health Care Financing Administration, the Assistant Secretary for Planning and Evaluation (ASPE) and the Assistant Secretary for Management and Budget. They generally concur with our recommendations. The actual comments received are in Appendix E.

The HCFA stated it hopes to use experience gained in implementing the new transfer policy authorized by the Balanced Budget Act to develop techniques that can be applied to a broader set of DRGs. The HCFA also expressed concern that the publication referenced in a draft report recommendation does not target the intended audience. To accommodate this concern we have modified our recommendation.

The ASPE provided suggestions for changes in wording and clarifications of the text which we have for the most part incorporated into the final report. They suggest that the report provide additional detail to the discussion about Federal requirements for discharge planning and the referral processes used by hospitals when discharging patients to nursing homes and home health agencies. Specifically, the ASPE recommended including a discussion of the criteria used by hospitals in selecting the post-acute provider type to which beneficiaries were referred. In an effort to better understand what factors are considered in making these post-hospital placement decisions, we asked discharge planners "When you determine that Medicare patients need post-hospital services, how do you decide whether they need home health agency services or they need to go to a nursing home?" Most respondents indicated that the following criteria were among the factors used to make this determination: the patients's medical needs, the degree of support available to the patient in their home, the preference of the patient and family, and the patient's ability to function safely at home. No one criterium was cited as being more important than the others.